

# BENEFIT SUMMARY



**Cigna Health and Life Insurance Co.**  
**For - Cooperative Educational Services, Inc**  
**Open Access Plus HDHPQ Plan**  
**HDHPQ OAP Plan**  
**Effective - 07/01/2026**

**Selection of a Primary Care Provider** - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

**Direct Access to Obstetricians and Gynecologists** - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	In-Network	Out-of-Network
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Plan Year Accumulation</b>	Your plan's deductibles, out-of-pockets and benefit level limits accumulate on a contract year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted.	
<b>Plan Coinsurance</b>	Plan pays 100%	Plan pays 80%
<b>Maximum Reimbursable Charge</b>	Not Applicable	300%
<b>Plan Deductible</b>	Individual - Employee Only: \$2,250 Family Maximum: \$4,500	Individual - Employee Only: \$2,250 Family Maximum: \$4,500
<ul style="list-style-type: none"> <li>• The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.</li> <li>• Plan deductible always applies before any benefit copay/deductible or coinsurance.</li> <li>• Plan deductible does not apply to in-network preventive services.</li> <li>• All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.</li> <li>• This plan includes a combined Medical/Pharmacy plan deductible.</li> <li>• In-network generic and preferred brand preventive drugs and products included in the preventive plus package will not be subject to deductible. This may apply to drugs for: Asthma, cholesterol lowering, depression, diabetes (including diabetic supplies and continuous glucose monitor supplies), heart disease and stroke, high blood pressure, osteoporosis, smoking cessation, prenatal vitamins, prescription vitamins.</li> </ul> <p><b>Note:</b> Services where plan deductible applies are noted with a caret (^).</p>		

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Plan Highlights		In-Network	Out-of-Network
<b>Plan Out-of-Pocket Maximum</b>		Individual - Employee Only: \$3,000 Family Maximum: \$6,000	Individual - Employee Only: \$3,000 Family Maximum: \$6,000
<ul style="list-style-type: none"> <li>The amount you pay for all covered expenses counts towards both your in-network and out-of-network out-of-pocket maximums.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All benefit copays/deductibles contribute towards your out-of-pocket maximum.</li> <li>Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.</li> <li>All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> </ul>			
Benefit	In-Network	Out-of-Network	
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>			
<b>Physician Services - Office Visits</b>			
<b>Primary Care Physician (PCP) Services/Office Visit</b>	Plan pays 100% ^	Plan pays 80% ^	
<b>Specialty Care Physician Services/Office Visit</b>	Plan pays 100% ^	Plan pays 80% ^	
<b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).			
<b>Surgery Performed in Physician's Office</b>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	
<b>Allergy Treatment/Injections and Allergy Serum</b> Allergy serum dispensed by the physician in the office	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit	
<b>Virtual Care</b>			
<b>Dedicated Virtual Providers - MDLIVE</b>			
<b>MDLIVE Urgent Virtual Care Services</b>	Plan pays 100% ^	Not Covered	
<b>MDLIVE Primary Care Services</b>	Plan pays 100% ^	Not Covered	
<b>MDLIVE Specialty Care Services</b>	Plan pays 100% ^	Not Covered	
<ul style="list-style-type: none"> <li>Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.</li> <li>For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).</li> <li>Lab services supporting a virtual visit must be obtained through dedicated labs.</li> <li>Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.</li> </ul>			
<b>Virtual Physician Services - Office Visits</b>			
<b>Primary Care Physician (PCP) Services/Office Visit</b>	Plan pays 100% ^	Plan pays 80% ^	
<b>Specialty Care Physician Services/Office Visit</b>	Plan pays 100% ^	Plan pays 80% ^	
<ul style="list-style-type: none"> <li>Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).</li> <li>Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.</li> </ul>			

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<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>NOTE:</b> Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).		
<b>Convenience Care Clinic</b>		
Convenience Care Clinic	Plan pays 100% ^	Plan pays 80% ^
<b>Preventive Care</b>		
<b>Preventive Care</b> Birth through age 21  Ages 22 and older <ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit.</li> <li>Annual Limit: Unlimited</li> </ul>	Plan pays 100%  Plan pays 100%	PCP: Plan pays 80% ^ Specialist: Plan pays 80% ^  PCP: Plan pays 80% ^ Specialist: Plan pays 80% ^
<b>Immunizations</b> Birth through age 21  Ages 22 and older	Plan pays 100%  Plan pays 100%	PCP: Plan pays 80% ^ Specialist: Plan pays 80% ^  PCP: Plan pays 80% ^ Specialist: Plan pays 80% ^
<b>Mammogram, PAP, and PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service.</li> </ul>	Plan pays 100%	Covered same as other x-ray and lab services, based on Place of Service
<b>Mental Health Wellness Examinations</b> <ul style="list-style-type: none"> <li>Limited to two examinations per contract year</li> </ul> <b>Note:</b> Covered when performed by a licensed Mental Health Provider. May be covered as part of the Preventive Care visit.	Plan pays 100% ^	Plan pays 80% ^
<b>Inpatient</b>		
<b>Inpatient Hospital Facility Services</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs		
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Plan pays 100% ^	Plan pays 80% ^
<b>Outpatient</b>		
<b>Outpatient Facility Services</b>	Plan pays 100% ^	Plan pays 80% ^

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<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Plan pays 100% ^	Plan pays 80% ^
<b>Emergency Services</b>		
<b>Emergency Room</b> <ul style="list-style-type: none"> <li>Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.</li> </ul>	Plan pays 100% ^	Plan pays 100% ^
<b>Urgent Care Facility</b> <ul style="list-style-type: none"> <li>Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.</li> </ul>	Plan pays 100% ^	Plan pays 100% ^
<b>Ambulance</b> Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 100% ^	Plan pays 100% ^
<b>Ambulance - Mental Health and Substance Use Disorder</b> <ul style="list-style-type: none"> <li>Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.</li> </ul>	Plan pays 100% ^	Plan pays 100% ^
<b>Inpatient Services at Other Health Care Facilities</b>		
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b> <ul style="list-style-type: none"> <li>Annual Limit: 120 days</li> </ul>	Plan pays 100% ^	Plan pays 80% ^
<b>Laboratory Services</b>		
<b>Physician's Services/Office Visit</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Independent Lab</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Outpatient Facility</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Radiology Services</b>		
<b>Physician's Services/Office Visit</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Outpatient Facility</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Advanced Radiological Imaging (ARI)</b>		
<b>Outpatient Facility</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Physician's Services/Office Visit</b>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Outpatient Therapy Services</b>		

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Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Outpatient Therapy Services</b> Annual Limits: <ul style="list-style-type: none"> <li>All therapies combined - Includes cognitive therapy, occupational therapy, physical therapy, pulmonary rehabilitation, and speech therapy - 60 days</li> <li>Limits are not applicable to mental health conditions for physical, speech and occupational therapies.</li> </ul> <b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Chiropractic Services</b> Annual Limit: <ul style="list-style-type: none"> <li>Chiropractic care - 60 days</li> </ul>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Cardiac Rehabilitation Services</b> Annual Limit: <ul style="list-style-type: none"> <li>Cardiac rehabilitation - 60 days</li> </ul>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Hospice</b>		
<b>Inpatient Facilities</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Outpatient Services</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.		
<b>Bereavement Counseling (for services not provided as part of a hospice program)</b>		
Services Provided by a Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
<b>Medical Pharmaceutical Drugs</b>		
<b>Outpatient Facility</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Physician's Office</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Home</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Note:</b> This benefit only applies to the cost of the infusion therapy drugs administered. This benefit does not cover the related facility, office visit or professional charges.		

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Maternity</b>		
<b>Initial Visit to Confirm Pregnancy</b>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges</b> (Global Maternity Fee)	Plan pays 100% ^	Plan pays 80% ^
<b>Office Visits in Addition to Global Maternity Fee</b> (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Delivery - Facility</b> (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit
<b>Abortion</b>		
<b>Abortion Services</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note:</b> Elective and non-elective procedures		
<b>Family Planning</b>		
<b>Women's Services</b>	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
<b>Men's Services</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
<b>Infertility</b>		
<b>Infertility Treatment</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.		
<ul style="list-style-type: none"> <li>Lifetime Maximum: Unlimited</li> </ul>		
<b>Outpatient Dialysis Services</b>		
<b>Physician's Services/Office Visit</b>	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Home Dialysis</b>	Covered same as plan's Home Health Care benefit	Covered same as plan's Home Health Care benefit
<b>Outpatient Facility Services</b>	Covered same as plan's Outpatient Facility Services benefit	Covered same as plan's Outpatient Facility Services benefit
<b>Outpatient Professional Services</b>	Covered same as plan's Outpatient Professional Services benefit	Covered same as plan's Outpatient Professional Services benefit
<b>Other Health Care Facilities/Services</b>		

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<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Home Health Care</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul> <b>Note:</b> Includes outpatient private duty nursing when approved as medically necessary	Plan pays 100% ^	Plan pays 80% ^
<b>Organ Transplants</b>		
<b>Inpatient Hospital Facility Services</b>		
LifeSOURCE Transplant Network® facility	Plan pays 100% ^	Not Applicable
Other Facility	Plan pays 100% ^	Plan pays 80% ^
<b>Inpatient Professional Services</b>		
LifeSOURCE Transplant Network® facility	Plan pays 100% ^	Not Applicable
Other Facility	Plan pays 100% ^	Plan pays 80% ^
<ul style="list-style-type: none"> <li>Travel Maximum - Cigna LifeSOURCE Transplant Network® facility only: After the plan deductible is met, Unlimited maximum per Transplant per Lifetime</li> </ul>		
<b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>	Plan pays 100% ^	Plan pays 80% ^
<b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li> <li>Includes related supplies</li> </ul>	Plan pays 100%	Plan pays 80% ^
<b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>	Plan pays 100% ^	Plan pays 80% ^
<b>Temporomandibular Joint Disorder (TMJ)</b> <ul style="list-style-type: none"> <li>Unlimited lifetime maximum</li> </ul> <b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Bariatric Surgery</b> <ul style="list-style-type: none"> <li>Surgeon Charges Lifetime Maximum: \$10,000</li> </ul> Treatment of Clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: <ul style="list-style-type: none"> <li>medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity</li> <li>weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision</li> </ul>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Routine Foot Care</b> <b>Note:</b> Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	Not Covered	Not Covered
<b>Hearing Aids</b> <ul style="list-style-type: none"> <li>Maximum of 2 devices (one per ear) per 24 months</li> <li>Includes testing and fitting of hearing aid devices at Physician Office Visit cost share</li> </ul>	Plan pays 100% ^	Plan pays 80% ^
<b>Wigs</b> <ul style="list-style-type: none"> <li>Unlimited maximum per 12 months for Wigs prescribed for hair loss due to chemotherapy.</li> </ul>	Plan pays 100% ^	Plan pays 100% ^

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<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Acupuncture</b> • Annual Limit: 12 days	Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Mental Health and Substance Use Disorder</b>		
<b>Inpatient Mental Health</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Outpatient Mental Health - Physician's Office</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Outpatient Mental Health - MDLIVE Behavioral Services</b>	Plan pays 100% ^	Not Covered
<b>Outpatient Mental Health - All Other Services</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Inpatient Substance Use Disorder</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Outpatient Substance Use Disorder - Physician's Office</b>	Plan pays 100% ^	Plan pays 80% ^
<b>Outpatient Substance Use Disorder - MDLIVE Behavioral Services</b>	Plan pays 100% ^	Not Covered
<b>Outpatient Substance Use Disorder - All Other Services</b>	Plan pays 100% ^	Plan pays 80% ^
Annual Limits: • Unlimited maximum		
Notes: • Inpatient includes Acute Inpatient and Residential Treatment. • Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc. • Outpatient - All other services - may include partial hospitalization, intensive outpatient services, Applied Behavior Analysis (ABA therapy), etc. • Services are paid at 100% after you reach your out-of-pocket maximum.		
<b>Important Note on Mental Health and Substance Use Disorder Coverage:</b> Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."		
<b>Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs</b>		
<b>Cigna Total Behavioral Health - Inpatient and Outpatient Management</b> • Inpatient utilization review and case management • Outpatient utilization review and case management • Partial Hospitalization • Intensive outpatient programs • Changing Lives by Integrating Mind and Body Program • Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management. • Narcotic Therapy Management • inMynd <sup>SM</sup> program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.		
Pharmacy	In-Network	Out-of-Network
<b>Cost Share and Supply</b>		

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Pharmacy	In-Network	Out-of-Network
<p><b>Cigna Pharmacy Cost Share</b></p> <ul style="list-style-type: none"> <li>Retail – up to 34-day supply (except Specialty up to 30-day supply)</li> <li>Home Delivery – up to 100-day supply (except Specialty up to 30-day supply)</li> </ul>	<p><b>Retail (per 34-day supply):</b>            Generic: You pay \$5 ^            Preferred Brand: You pay \$20 ^            Non-Preferred Brand: You pay \$35 ^</p> <p><b>Retail and Home Delivery (per 100-day supply):</b>            Generic: You pay \$10 ^            Preferred Brand: You pay \$40 ^            Non-Preferred Brand: You pay \$70 ^</p>	<p><b>Retail:</b>            You pay 20% ^            Your plan pays 80% ^</p> <p><b>Home Delivery:</b>            Same as retail out-of-network</p>
<ul style="list-style-type: none"> <li>Retail drugs may be obtained in-network at a wide range of pharmacies across the nation.</li> <li>You can choose to fill your medications in a 34- or 100-day supply at any network pharmacy.</li> <li>Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.</li> <li>When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).</li> <li>Pharmacist will dispense the brand medication, and the patient will pay the generic cost share, when the medication is part of the Brand-for-Generic Substitution Program (DAW9).</li> <li>Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.</li> <li>Specialty Drugs provided at Home Delivery at the Retail (per 30-day supply) cost share.</li> <li>When using a glucagon-like peptide 1 (GLP-1), it is important to have extra clinical care and support from your doctor and pharmacist. There are pharmacies in your plan's network that can help including Evernorth EnGuide<sup>SM</sup> Pharmacy.</li> </ul>		
<p><b>Preventive Drugs:</b>            Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, in-network generic and preferred brand preventive drugs and products included in the preventive plus package will not be subject to deductible and will be provided at no charge. This may apply to drugs for:            Asthma, cholesterol lowering, depression, diabetes (including diabetic supplies and continuous glucose monitor supplies), heart disease and stroke, high blood pressure, osteoporosis, smoking cessation, prenatal vitamins, prescription vitamins</p>		
<p><b>Drugs Covered</b></p> <p><b>Prescription Drug List:</b>            Your Cigna Legacy Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.            Some highlights:</p> <ul style="list-style-type: none"> <li>Coverage includes self administered injectables and optional injectable drugs – but excludes infertility drugs.</li> <li>Contraceptive devices and drugs are covered with federally required products covered at 100%.</li> <li>Lifestyle drugs are covered - limited to sexual dysfunction.</li> <li>Oral fertility drugs are covered.</li> </ul>		

## Pharmacy Program Information

### Pharmacy Clinical Management

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Quantity over time edits and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

### Patient Assurance Program

Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications count toward meeting both your deductible and out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications count toward meeting both your deductible and out-of-pocket maximum.

## Additional Information

### Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

### Cigna Diabetes Prevention Program in collaboration with Omada

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

### Comprehensive Oncology Program

- Care Management outreach
- Case Management

Included

### Healthy Pregnancies/Healthy Babies

- Care Management outreach
- Maternity Case Management
- Neo-natal Case Management

\$150 (1st trimester) / \$75 (2nd trimester) - Option 3

## Additional Information

### Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (300%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the Maximum Reimbursable Charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a contract year deductible and Maximum Reimbursable Charge limitations.

### Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the in-network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (out-of-network) provider.
2. The allowable amount used to determine the plan's benefit payment for covered Emergency Services rendered in an out-of-network hospital, or by an out-of-network provider in an in-network hospital, is the amount agreed to by the out-of-network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable in-network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the out-of-network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

### Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay Secondary to Medicare Part A and B as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;
- (b) an Employee's Domestic Partner who is also eligible for Medicare due to age;
- (c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

### Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

### One Guide

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

### Pre-Certification - Continued Stay Review - Basic Care Low Management Inpatient - required for all inpatient admissions

In-Network: Coordinated by your physician

Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- The lesser of 50% or \$500 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

**Pre-Existing Condition Limitation (PCL)** does not apply.

## Additional Information

### Well-Being Solution: Core Plus

- Health assessment
- Device/app integration
- Personalized online content and data-driven actions
- Social connections/challenges
- Incentive administration

### Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

## Definitions

**Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.

**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.

**Place of Service** - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.

**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

## Exclusions

### What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
  - o any instance where Cigna determines that a provider or Pharmacy did not bill you for or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
  - o charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:

- require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
  - deny the payment of benefits in connection with the Covered Expense, regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
  - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- Charges or payment for healthcare-related services that violate state or federal law.
  - Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
  - For or in connection with experimental, investigational or unproven services.
  - Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
    - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
    - o Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
    - o The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
    - o The subject of an ongoing phase I, II or III clinical trial (other than successfully completed phase III clinical trial of the FDA), except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.
  - In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as

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## Exclusions

experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed and is recognized for the treatment of cancer in any one of the following: the U.S. Pharmacopeia Drug Info. Guide for the Health Care Professional; the AMA Drug Evaluations; or the American Society of Health System Pharmacists' American Hospital Formulary Drug Service Information. Peer-reviewed medical literature means a published study in a journal or other publication in which original manuscripts have been critically reviewed for scientific accuracy, validity, and reliability by unbiased international experts, and that has been determined by the International Committee of Medical Journal Editors to have met its Uniform Requirements for Manuscripts submitted to Biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or any carrier that delivers, issues for delivery, renews, amends or continues a health insurance policy in this state.

- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy; Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an injury to teeth are covered.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- Court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- Infertility services when the infertility is caused by or related to voluntary sterilization; donor charges and services; cryopreservation of donor sperm, eggs; gestational carriers and surrogate parenting arrangements; and any experimental, investigational or unproven infertility procedures or therapies. Harvesting eggs for a surrogate is a covered expense if harvested from a Member.
- Reversal of male and female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
- Medical and Hospital care and costs for the child of your Dependent child, beyond the first 61 days of life, unless the child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

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## Exclusions

- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures (other than as described in Covered Expenses).
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames, contact lenses and associated services (exams and fittings) (except the initial set after treatment of keratoconus or following cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Acupuncture, unless part of Pain Management.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered.
- Membership costs and fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Health and beauty aids, cosmetics and dietary supplements.
- To the extent permitted by law, for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit. For Medical Benefits, this will not apply to any of the Policyholder's partners, proprietor's or corporate officers, however, if payment is made for expenses in the event that third-party liability is determined and satisfied (whether by settlement, judgment, arbitration or otherwise), Cigna shall be refunded the lesser of: the amount of Cigna's payment for such expenses; or the amount actually received from the third party for such expenses. In the event that a workers' compensation claim is filed, Cigna shall have a lien on the proceeds of any award or settlement to the extent of its payment of benefits.
- Charges for the delivery of virtual medical and health-related services and remote monitoring through facsimile, email or text messaging only and those that are telephone only unless provided by in-network virtual providers or a provider enrolled in the Connecticut Medical Assistance Program (CMAP) providing health care or health services to a CMAP recipient.
- Massage therapy.
- Any services, supplies or equipment intended primarily to provide a safe environment, including, but not limited to: helmets, safety goggles/glasses, bed exit monitors, restraints, telephone alert systems, fire extinguishers, smoke/carbon monoxide detectors, fall detection systems, safety rails, fixtures to real property to create a safe surrounding, first aid kits, automatic external defibrillators.

### **These are only the highlights**

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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*Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation.*

EHB State: CT

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# Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

## Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc. Cigna HealthCare of California, Inc. Cigna HealthCare of Colorado, Inc. Cigna HealthCare of Connecticut, Inc. Cigna HealthCare of Florida, Inc. Cigna HealthCare of Georgia, Inc. Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator  
P.O. Box 188016, Chattanooga, TN 37422,  
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

## U.S. Department of Health and Human Services

200 Independence Avenue,  
SW Room 509F, HHH Building  
Washington, DC 20201

**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at  
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

## Proficiency of Language Assistance Services

**English – ATTENTION:** If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1- 800-244-6224 (TTY: Dial 711) or speak to your provider.

**Spanish – ATENCIÓN:** Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

**Chinese – 注意:** 如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

**Vietnamese – XIN LƯU Ý:** Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

**Korean – 주의:** 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십시오.

**Tagalog – PAUNAWA:** Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

**Russian – ВНИМАНИЕ:** Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

**Arabic - تنبيه:** إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم. أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711) 1-800-244-6224 (TTY: 711)

**French Creole – ATANSYON:** Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244- 6224 (TTY: Rele 711) oswa pale ak founisè ou a.

**French – ATTENTION :** Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

**Portuguese – ATENÇÃO:** Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

**Polish – UWAGA:** Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

**Japanese – 注意:** 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224 (TTY: 711 にダイヤル) に電話するか、提供者に話してください。

**Italian – ATTENZIONE:** Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: componi il 711) o parla con il tuo fornitore.

**German – Achtung:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

**Persian (Farsi) - همچنین،** وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنید، توجه:

اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید: TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید

## Summary of Benefits Cigna Health and Life Insurance Company



### Cigna Healthcare Vision Cooperative Educational Services PPO (E1)

Welcome to Cigna Vision Schedule of Vision Coverage Effective Date: July 1, 2026			
Vision Services and Frequency	In-Network Plan Coverage**	In-Network Member Cost***	Out-of-Network Reimbursement
<b>Exam and Professional Services:</b> Frequency*: once per 12 month  <div style="text-align: right;"> <b>Eye Exam</b>                          Retinal Screening                     </div>	100% after Copay Not Covered	\$0 Copay Up to \$39	Up to \$45 Allowance Not Covered
*Your Frequency Period begins on January 1 (Calendar year basis)			
<b>Definitions:</b> <b>Copay:</b> the amount you pay towards your exam. <b>Coinsurance:</b> the percentage of charges Cigna will pay. Customer is financially responsible for the balance. <b>Allowance:</b> the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.			
<ul style="list-style-type: none"> <li>To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.</li> <li>If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.</li> </ul>			
<b>In-Network Coverage Includes**:</b> <ul style="list-style-type: none"> <li>One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses.</li> <li>Retinal Screening for <u>non-medically</u> necessary retinal imaging, which takes digital pictures of the inside of the eye. <i>Does not replace dilation.</i></li> </ul>			
<b>In-Network Value Added Savings**</b> <ul style="list-style-type: none"> <li>Up to 30% off additional complete pairs of glasses (frame and lenses)</li> <li>20% off any item not covered by the plan, including non-prescription sunglasses, but excluding professional services***</li> </ul>			
<i>Interested in Laser Vision Correction service such as LASIK? Visit your MyCigna.com and search for Healthy Rewards® for details.</i>			
** Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information ***Provider participation is 100% voluntary and subject to applicable by law, please check with your Eye Care Professional for any offered discounts; stated Customer Cost, up to maximums, are subject to change without notice.			
<b>What's Not Covered:</b> <ul style="list-style-type: none"> <li>Orthoptic or vision training and any associated supplemental testing</li> <li>Medical or surgical treatment of the eyes</li> <li>Any eye examination, or any corrective eyewear, required by an employer as a condition of employment</li> <li>Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related</li> <li>Charges in excess of the usual and customary charge for covered Services</li> <li>Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy</li> <li>Experimental or non-conventional treatment or device</li> <li>Claims submitted and received in-excess of twelve (12) months from the original Date of Service</li> </ul>			

## How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

### 1. Finding a doctor

There are three ways to find a quality eye doctor in your area:

1. Log into myCigna.com, under "Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision – serviced by EyeMed Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor", select Employer or School, click on Additional Directories and select Cigna Vision serviced by EyeMed Directory.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

### 2. Schedule an appointment

Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna Vision serviced by EyeMed Proof of Coverage Identification at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

### 3. Out-of-network plan reimbursement

#### How to use your Cigna Vision Benefits

Send a completed Cigna Vision service by EyeMed claim form and itemized receipt to: Cigna Vision, Claims Dept. c/oFAA  
PO Box 8504, Mason, OH 45040-7111

To get a Cigna Vision serviced by EyeMed claim form:

- Go to **Cigna.com** and go to Forms, Vision Forms, select the Cigna Vision serviced by EyeMed form
- Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Read your plan carefully – this benefit summary provides a very brief description of the important features of your plans. This is not the insurance contract. Your full rights and benefits are expressed in the actual plan documents that are available to you upon request or a copy of the NH Vision Outline of Coverage is available and can be downloaded at [Health Insurance & Medical Forms for Customers | Cigna](#) under Vision Forms. Participating providers are independent contractors solely responsible for your routine vision examinations and products.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. Healthy Rewards® - is a discount program, not an insured benefit.

# Discrimination is against the law

## Vision coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCION: Si usted habla un idioma que no sea ingles, tiene a su disposicion servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al numero que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

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If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com) or by writing to the following address:

### Cigna Healthcare

Nondiscrimination Complaint Coordinator  
PO Box 188016  
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to [ACAGrievance@Cigna.com](mailto:ACAGrievance@Cigna.com). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. Call 1.888.353.2653 (TTY dial 711 for operator, then dial 1-844-230-6498).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1.888.353.2653 (TTY: marque 711 para hablar con un operador y luego marque 1-844-230-6498).

**Chinese** – 注意：我們可為您免費提供語言協助服務。請致電 1.888.353.2653（聽語障人士請撥打 711（聽語障專線）由操作人員為您服務，然後撥打 1-844-230-6498）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1.888.353.2653 (TTY xin quay số 711 để kết nối với tổng đài, sau đó quay số 1-844-230-6498).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.353.2653번으로 문의하십시오(TTY는 교환원 연결을 위해 711번으로 전화하신 후, 1-844-230-6498번으로 전화하십시오).

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Tumawag sa 1.888.353.2653 (Para sa TTY, i-dial ang 711 para sa operator, pagkatapos ay i-dial ang 1-844-230-6498).

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.353.2653 (линия TTY: наберите 711 для соединения с оператором, затем наберите 1-844-230-6498).

**Arabic** – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.353.2653 (يُنْبَغِي لمستخدمي TTY الاتصال على الرقم 711 للتحدث إلى عامل الهاتف، ثم الاتصال على الرقم 1-844-230-6498).

**French Creole** – ATANSYON: Gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1.888.353.2653 (TTY konpoze 711 pou pale ak yon operatè, apres a konpoze 1-844-230-6498).

**French** – ATTENTION : Des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1.888.353.2653 (ATS: composez le 711 pour joindre l'opérateur, puis composez le 1-844-230-6498).

**Portuguese** – ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue 1.888.353.2653 (TTY: marque 711 para o telefonista e, em seguida, marque 1-844-230-6498).

**Polish** – UWAGA: Możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.888.353.2653 (użytkownicy TTY powinni dzwonić pod numer 711, aby otrzymać połączenie z telefonistą, a następnie wybrać numer 1-844-230-6498).

**Japanese** – 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1.888.353.2653 にお電話ください (TTYをご利用の場合は、711 をダイヤルしてオペレーターに接続してから 1-844-230-6498 におかけください)。

**Italian** – ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1.888.353.2653 (TTY: comporre il 711 per l'operatore, quindi comporre il numero 1-844-230-6498).

**German** – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: Rufen Sie die Nummer 1.888.353.2653 an (TTY-Benutzer wählen 711 für die Vermittlung und dann 1-844-230-6498).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. با شماره 1.888.353.2653 تماس بگیرید (YTT شماره 711 را برای اپراتور گرفته و سپس 1-844-230-6498 را شماره گیری کنید).

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